Alaska Health Care Commission

Findings and Recommendations

2009-2013

This document contains all of the official findings and recommendation statements of the Alaska Health Care Commission since its initial inception under Administrative Order #246 for 2009, and continuing in late 2010 following establishment in statute under AS 18.09.010.

Official findings and recommendations are drafted by the commission, go through a public comment period, and are finalized and approved each calendar year. Voting records documenting individual votes on each statement are included in the commission's annual reports available on the web at:
http://dhss.alaska.gov/ahcc/Pages/Reports/default.aspx

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Findings and Recommendations 2009-2013

I. 2013 Annual Report

A. Ensure the best available evidence is used for making decisions

Findings

A. Waste in the health care system due to misused medical resources is estimated to represent as much as 30% of health care spending.[1]

B. The application of high grade evidence in clinical decision-making can increase the effectiveness of medical treatment, improve the quality of health care, and reduce wasteful health care spending.[1]

C. Key definitions for understanding the application of evidence in medical decisions include:

- **Evidence-based medicine:** The use of the scientific method and application of valid and useful science to inform health care provision, practice, evaluation and decisions.
- **Critical appraisal**: Scientific evaluation of evidence for validity through review for clinical usefulness and for systematic errors resulting from selection bias, information bias and/or confounding.
- **High grade evidence**: Medical evidence determined through critical appraisal to be of high quality and clinically useful.

D. Public and private health care sectors have demonstrated an increasing interest in applying evidence-based medicine to policy and practice in response to high and rising costs and variations in quality of health care. Examples of federal, State, and private medical community initiatives include:

- The **Choosing Wisely Campaign**, which is an initiative of the ABIM Foundation to help physicians and patients engage in conversations to reduce overuse of tests and procedures, and support physician efforts to help patients make smart and effective care choices. Over 25 medical specialty associations have partnered with ABIM to identify tests and treatments that are overused or not effective. http://www.choosingwisely.org/
    - Consumer Reports has partnered with Choosing Wisely to convert the clinical information into patient education materials. www.ConsumerHealthChoices.org
    - The National Business Coalition on Health partnered with Choosing Wisely to develop the Choosing Wisely Employer Toolkit. http://www.nbch.org/choosing-wisely-employer-toolkit

[1] IOM (Institute of Medicine). 2013. *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America.* Washington, DC: The National Academies Press.

- The **Effective Health Care Program** in the U.S. Agency for Healthcare Research & Quality, which produces effectiveness and comparative effectiveness research for clinicians, consumers and policy makers. This program produces a variety of tools and resources for patients and clinicians, including patient decision aids, research summaries for patients and for clinicians, and continuing medical education modules for clinicians. http://www.effectivehealthcare.ahrq.gov/
- The **Center for Evidence-based Policy** based in the Oregon Health & Science University. Current Center initiatives include the Drug Effectiveness Review Project, which supports the application of high grade evidence on effectiveness and safety of drugs to public policy and decision making; and the Medicaid Evidence-based Decisions Project, which makes high grade evidence available to participating State Medicaid Programs to support benefit design and coverage decisions. http://www.ohsu.edu/xd/research/centers-institutes/evidence-based-policy-center/
- **Washington State's Technology Assessment Program**, which determines if medical treatments and services purchased with state health care dollars are safe and effective. The goals of this program are to make:
    - Health care safer by relying on scientific evidence and a committee of practicing clinicians;
    - Coverage decisions of state agencies more consistent;
    - State purchased health care more cost effective by paying for medical tools and procedures that are proven to work; and,
    - Coverage decision process more open and inclusive by sharing information, holding public meetings, and publishing decision criteria and outcomes.
    - http://www.hca.wa.gov/hta/Pages/index.aspx

E. Involvement of health care providers and patients in decision-making is essential to the successful application of evidence-based medicine to clinical practice and public and private payer policies.

F. Existing mechanisms to assess patient compliance with evidence-based medical recommendations are limited.

G. Assessing the outcomes of health care interventions is challenging due to limitations on collecting and sharing data among patients, clinicians, payers, and government agencies.

Recommendations

1. The Commission recommends that Commissioners of State agencies responsible for purchase of medical services (Health & Social Services, Administration, Labor & Workforce Development, and Corrections) and the President of the State University System:

a. Incorporate high grade evidence-based medicine when making determinations relative to provider payment methods and health plan benefit design (such as covered services, prior authorization requirements, and patient cost-sharing differentials); and in so doing:

- Coordinate development and application of evidence-based medicine policies across programs and departments to create a consistent approach supporting improved quality and efficiency in Alaska's health care system.

- Support a transparent policy development process.

- Develop policies that do not restrict access to appropriate treatment, but foster informed discussions between patients and clinicians to support individualized, evidence-based choices to improve the quality of health care.

- Ensure prior authorization processes are efficient, prompt, and user-friendly for providers and patients.

b. Provide learning and skill development opportunities in critical appraisal concepts and techniques for all staff involved in analysis, consultation, or decision-making related to payment for medical services.

c. Involve health care providers and consumers in training opportunities and decision-making applying evidence-based medicine in public policy.

d. Provide patient decision-support tools to assist State health insurance plan members and public program clients to make effective care choices in consultation with their clinicians.

e. Promote provider-patient relationships through payment structures and benefit designs that support providers in monitoring patient compliance, and support patients to comply with best practices for managing chronic conditions such as asthma, diabetes, hypertension, and hyperlipidemia.

2. The Commission recommends the University of Alaska President incorporate evidence-based medicine and critical appraisal principles in clinical and health service administration academic curricula.

B. Engage employers to improve health plans and employee wellness

Findings

A. Employers play an important role in the health of their employees, and in the value — the cost, quality and outcomes — of health care services purchased through employee health plans.

B. CEOs who take control of health care like any other supply chain issue and adopt health and health care improvement as a business strategy are improving employee wellness and productivity, containing health care cost growth and improving health care quality for their companies.

C. Essential elements of employee health management programs that demonstrate success in driving down health care costs and improving quality and employee health outcomes include:

- **Evidence-Based Medicine.** The application of high-grade medical evidence in clinical decision-making can increase the effectiveness of medical treatment, improve quality of care, and reduce wasteful health care spending.[1] Employers can apply evidence-based medicine through provider payment methodologies and health plan benefit design including covered services, pre-certification processes, and patient co-sharing differentials.

- **Price Sensitivity.** Traditional health plans with low deductible and co-payment requirements insulate the plan member/patient from experiencing the direct cost of a service; providing little incentive for the covered patient to engage as an informed consumer and as a partner with their health care provider in addressing questions regarding the need, efficacy and price for a service. Consumer-driven health plans that include employer-supported Health Savings or Health Reimbursement Accounts, off-set by higher deductibles and co-insurance, engage members to shop for price, service and quality, and demonstrate cost savings.

- **Price & Quality Transparency.** Employees/plan members must have easy access to information on the prices charged for health services, the amount their health plan will reimburse, and the quality of services available in order to be informed and engaged health care consumers.

- **Pro-active Primary Care Emphasis.** Primary care must be easily accessible to employees in terms of physical location and convenience, and also in terms of low or no co-insurance costs. Preventive services, easy access care for acute illness and minor injuries, and pro-active support for management of chronic conditions avoids more costly care that might otherwise require a higher level of care and also higher costs associated with later treatment of conditions that might worsen with time.

- **Support for Healthy Lifestyles.** Employers' policies and working conditions can be designed to support an employee's ability to make healthy choices, and can also provide employees with incentives to improve and maintain their personal health.

D. Employer-led health coalitions in other states are actively engaged in leading health and health care improvement initiatives in their communities. The National Business Coalition on Health includes 52 state, regional and community coalitions of public and private sector employers from across the U.S involved in initiatives to empower consumers and improve value and health.[2]

- Large employer partnerships and union trust partnerships present opportunities for aligning interests and strategies aimed at improving employee health and value in health purchasing.
- Employer coalitions can partner with health care providers in their regions and communities to collaborate on health and health care improvement initiatives.
- All-Payer Claims Databases provide a potential data source for employer coalitions to study information about utilization, quality, preventive services, and pricing.

E. Market forces affecting pricing for health care services are influenced by the size and structure of Alaska's health care market. Lack of health care provider competition, and fragmentation and small populations among employer groups, enhance provider leverage to set prices and limits employers' purchasing power to negotiate health care prices in Alaska.

- Partnerships among large employers and/or among union health trusts can enable opportunities for aligning interests and strategies aimed at improving employee health and improving value in health care purchasing.
- Aggregation of enough covered lives sufficient to leverage purchasing power for price negotiation purposes would be a challenge in Alaska. Additionally, combining public insurance

[2] National Business Coalition on Health: http://www.nbch.org/

program plan membership could potentially negatively impact prices for private payers if private employers are not included in the aggregation strategy.

- Aggregation of covered lives presents an opportunity for implementing other important strategies for improving value.
- Private insurers provide scale through aggregation of their plan members and are able to leverage implementation of value improvement strategies.
- The State of Alaska, Department of Administration, has 62,000 covered lives in the AlaskaCare retiree health plan. This population consists of 16,000 under 65 retirees, 22,000 Medicare and 24,000 dependents. The non-diminishment clause of the Alaska State Constitution and subsequent decisions of the Alaska Supreme Court limit changes to the retiree health plan. Four billion dollars of the retirement systems' unfunded liability is attributed to retiree health care costs. Due to this unfunded liability any changes that add to retiree health plan expense must be balanced with cost-saving measures.

F. Market forces affecting pricing for health care services are impacted by state laws and regulations in Alaska. There are state laws and regulations in place that influence the market in such a way as to drive prices higher for the consumer.[3]

- Lower physician discounts in Alaska can be at least partly explained by the relative lack of competition among providers, particularly for specialty care. In many areas, including Anchorage, there are a limited number of providers in any given specialty (sometimes only one provider group). As a result, physicians can largely dictate the fees they are paid by commercial payers.
- Relative provider leverage may be further exacerbated by Alaska's regulation requiring usual and customary charge payment to be at least equal to the 80th percentile of charges by geographic area. Since many providers have over 20% of their market share, this implies that those providers can ensure that their charges are below the 80th percentile and therefore, receive payment for their full billed charges.[4]
- A separate state law requires payers to reimburse non-contracted providers directly instead of through the patient, removing incentives typically used by payers to encourage providers to join their networks.[5]

G. The Affordable Care Act "Cadillac Tax" on high-priced insurance plans, while not in effect until 2018, is beginning to impact employers' decisions and union negotiations regarding employee health benefits. This new tax will impose a 40% excise tax on the portion of health plan premiums that exceed $10,200 annually for individual plans and $27,500 for family plans. The Anchorage School District reports that this impending tax was a factor in recent negotiations with district employees' unions regarding benefit packages.[6]

H. Workers' compensation costs in Alaska are the highest in the nation, primarily due to high medical benefit costs. The number of occupational injuries in Alaska has declined by 4-5% per year over the

[3] "Drivers of Health Care Costs in Alaska and Comparison States." Milliman, Inc., November 29, 2011.
[4] Alaska Administrative Code: 3 AAC 26.110
[5] Alaska Statute: AS 21.54.020
[6] Testimony by Anchorage School District Budget Director, Mark Foster, to Commission. October 10, 2013

past 15 years, most recently decreasing 7% between 2011 and 2012; however, Alaska's worker's compensation premiums have been increasing and were the highest in the U.S. in 2012.[7]

- Alaska's workers' compensation premiums ranked 28th highest in the U.S. in 2000 and had increased to second highest in the nation by 2004. Since 2004 Alaska has ranked either first or second every year for the highest workers' compensation premium cost in the U.S.
- At 76% of total claim costs, the proportion of medical claims costs is substantially higher in Alaska than the national average of 59%. Alaska's average medical claim cost is $48,200 per case compared to the national average of $28,000.
- Alaska's allowable workers' compensation medical fees are the highest in the nation, according to a 2012 survey of workers' compensation medical fee schedules conducted by the Workers' Compensation Research Institute.
- Alaska's workers' compensation medical fee schedule demonstrates an inefficient allocation of resources. The current fee schedule based on usual and customary billed charges is inherently inflationary and interferes with market function that might otherwise contain cost growth.
- Prescription drug costs comprised 19% of total workers' compensation medical claims costs in Alaska in 2011. A 2011 National Council on Compensation Insurance report on Alaska's workers' compensation program identified over-prescription of opioid narcotics and drug repackaging by physicians as the primary cost drivers of pharmaceutical costs.
- Application of medical treatment guidelines has demonstrated improved patient outcomes and cost reduction in other state workers' compensation programs that have adopted this practice.

I. Dispensing of repackaged prescription medications by prescribing clinicians can result in significantly increased consumer costs and may negatively impact patient safety and quality of care. Prescribing clinicians who buy and dispense prescription medications from drug repackaging firms, or who themselves repackage and dispense drugs and bill for reimbursement as an ancillary cost rather than under the original National Drug Code (NDC), may significantly inflate charges. While such practice may increase patient convenience and compliance, it also limits patient choice and often significantly increases price. It may also increase risk of duplicate or harmful drug interactions for patients with multiple clinicians. In addition, such practice is not subject to State pharmacy practice standards that govern record keeping, labeling, and security of dispensed pharmaceuticals.

J. Abuse of prescription opioid narcotics is a critical personal, employer and public health concern. Drug overdose deaths now exceed motor vehicle deaths nationally and more Americans die from prescription drug related deaths than from heroin and cocaine combined.[8] Alaska ranked 5th in the nation in 2008 for deaths due to prescription drug overdose (18.1 deaths/100,000 people; age-adjusted).[9]

- Drug overdose death rates in the U.S. have more than tripled since 1990. In 2008 more than 36,000 people died from drug overdoses, and most of these deaths were caused by prescription

[7] "Alaska Division of Workers' Compensation 2012 Annual Report," Department of Labor & Workforce Development; National Council on Compensation Insurance 2012 Alaska State Advisory Forum; "2012 Workers' Compensation Premium Rate Ranking Summary," Oregon Department of Consumer and Business Services, October 2012.

[8] "Prescription Drug Abuse: Strategies to Stop the Epidemic," Trust for America's Health, October 2013.

[9] "Policy Impact: Prescription Drug Overdose State Rates," Centers for Disease Control & Prevention, November 2011.

drugs. Nearly three out of four prescription drug overdoses are caused by prescription opioid painkillers.[10]

- The number of emergency department visits in the U.S. due to misuse and abuse of prescription painkillers nearly doubled between 2004 and 2009.[10]
- For every one death due to prescription painkillers there are an additional 10 treatment admissions for abuse, 130 people abusing or dependent, and 825 non-medical users. More than 3 out of 4 people who misuse prescription painkillers use drugs prescribed to someone else. [10]
- Misuse and abuse of prescription painkillers is estimated to cost the nation $53.4 billion annually in lost productivity, medical costs and criminal justice costs. [8]
- Clinicians who know and follow evidence-based guidelines for safe and effective use of prescription painkillers are less likely to unintentionally contribute to the problem of opioid misuse and abuse.[11]
- Clinician access to patient-specific up-to-date information at the point of care is a valuable tool for supporting appropriate prescribing practices. [11]
- Other states, such as Washington and Oklahoma, have implemented legislative solutions that are demonstrating success at impacting the problem of prescription drug abuse.

Recommendations

1. The Alaska Health Care Commission recommends the Commissioner of the Department of Health & Social Services investigate and the Alaska Legislature support implementation of a mechanism for providing the public with information on prices for health care services offered in the state, including information on how quality and outcomes compare, so Alaskans can make informed choices as engaged consumers.

a. The Alaska Health Care Commission recommends the Commissioner of the Department of Health & Social Services and Alaska Legislature immediately proceed with caution to establish an All-Payer Claims Database and take a phased approach. As part of the process:
    - Address privacy and security concerns
    - Engage stakeholders in planning and establishing parameters
    - Establish ground rules for data governance
    - Ensure appropriate analytical support to turn data into information and support appropriate use
    - Focus on consumer decision support as a first deliverable
    - Start with commercial insurer, third-party administrator, Medicaid and Medicare data collection first, then collaborate with other federal payers.

2. The Alaska Health Care Commission recommends the Division of Insurance consider modifying the current usual and customary charge payment regulation to eliminate the unintended adverse pricing consequence. [4]

3. The Alaska Health Care Commission recommends the State of Alaska, as a major employer in the state, play a leadership role for all Alaskan employers by continuing to develop and share strategies already underway to improve employee health and productivity and increase health care value. The

[10] "Prescription Painkiller Overdoses in the US," CDC Vital Signs, US Centers for Disease Control & Prevention, November 2011.
[11] "Issue Brief: Rx Drug Abuse and Diversion," American Medical Association, 2013.

Commission recommends the Department of Administration and the University of Alaska system take a comprehensive approach by including all the essential elements of a successful employee health management program: Evidence-based medicine, price sensitivity, price and quality transparency, pro-active primary care, and healthy life-style support for employees.

4. The Alaska Health Care Commission recommends the Alaska Legislature enact changes in the State Workers' Compensation Act to contain medical costs in the program and improve quality of care and outcomes for injured workers, including:

a. Implementation of evidence-based treatment guidelines;
b. Restriction of reimbursement for repackaged pharmaceuticals;
c. Restriction of reimbursement for opioid narcotic prescriptions exceeding a maximum appropriate dosage; and,
d. Revision of the fee-for-service fee schedule.

5. The Alaska Health Care Commission recommends the Alaska Medical Board, Board of Nursing, Board of Dental Examiners, and Board of Pharmacy in the Department of Commerce, Community & Economic Development establish guidelines governing the practice of prescription medication dispensing by prescribing clinicians.

6. The Alaska Health Care Commission recommends the State of Alaska adopt aggressive prescription opioid control policies and programs, including:

a. The Commission recommends the Alaska Board of Pharmacy in the Department of Commerce, Community & Economic Development and the Alaska Legislature strengthen the Alaska Prescription Drug Monitoring Program by upgrading the controlled substances prescription database to real-time and providing support for on-going operation of the database.

b. The Commission recommends the Alaska Medical Board, Board of Nursing, and Board of Dental Examiners in the Department of Commerce, Community & Economic Development require one-time Continuing Medical Education Credits on over-prescription of opioids and how to spot potential abusers as a condition of licensure or re-licensure for clinicians with prescription authority.

c. The Alaska Health Care Commission recommends the Alaska Medical Board, Board of Nursing, Board of Dental Examiners, and Board of Pharmacy in the Department of Commerce, Community & Economic Development work together to identify and adopt guidelines regarding appropriate dosage for prescription of opioid narcotics.

d. The Commission recommends the Commissioners of State agencies responsible for purchase of medical services (Health & Social Services, Administration, Labor & Workforce Development, and Corrections) and the President of the State University System track adoption of opioid control regulations by Alaska's professional licensing boards for prescribing clinicians, and collaborate to adopt common payment practices for reimbursement for opioid narcotics should the professional boards decide against regulation of their professions.

C. Increase price and quality transparency; Strengthen the health information infrastructure

Findings

A. There currently is insufficient data and information to support consumerism in Alaska's health care market. Empowering consumers and health care providers with access to information on the cost and quality of care is an important strategy for improving value in Alaska's health care system.

B. Some patients lack incentives to seek value in their health care decisions. Normal supply-and-demand price mechanisms do not always work when consumers are insulated from the cost of a good or service, which is one effect of the third-party payer health insurance system. Consumers who share directly in the out-of-pocket cost of their health care purchases are more likely to make decisions based on value (price and quality).

C. State government and other payers require high quality health data sources and health analytics capacity to provide the information needed to guide payment reform and health care delivery improvement policies.

D. Alaska's Hospital Discharge Database is an important source of health care data, and is a good example of collaboration between a health care provider group and the State to make health care data more transparent. However, this data set is currently incomplete due to lack of full participation by all of Alaska's hospitals. It is also insufficient for supporting full cost and quality transparency in that it represents care provided only by acute care hospitals and does not include other facilities such as ambulatory surgery centers or other provider types.

E. A number of states have implemented or are in the process of planning All-Payer Claims Databases (APCDs) to complement data from their Hospital Discharge Data and Medicaid Management Information Systems.[12] APCDs:

- Are large-scale databases that systematically collect and aggregate medical, dental and pharmacy claims data from payers such as commercial insurers, third-party administrators, Medicaid and Medicare.
- Have multiple potential uses, including:[13]
  - Price and quality transparency for the public
  - Utilization and cost analyses for policy makers, employers and other payers
  - Clinical quality improvement initiatives by and for providers
  - Understanding population health trends for public health purposes
- Offer valuable sources of information about outpatient services and health care payments for those states that have implemented them.
- Minimize the burden on health care providers as the aggregated data from payers is an efficient alternative to collecting data directly from individual providers.

[12] All Payer Claims Database Council: http://www.apcdcouncil.org/

[13] APCD Showcase Website, providing examples and case studies of State APCD uses: http://www.apcdshowcase.org/

- Would provide a tool for supporting multiple Core Strategies recommended by the Commission, including transparency, payment reform, prevention, and the health information infrastructure.

Recommendations

1. The Alaska Health Care Commission recommends the Commissioner of the Department of Health & Social Services mandate participation in the Hospital Discharge Database for the purpose of providing data that will lead to health care policy decisions that will improve the health of Alaskans, and to encourage federal facility participation in that database.

2. The Alaska Health Care Commission recommends the Commissioner of the Department of Health & Social Services and the Alaska Legislature immediately proceed with caution to establish an All-Payer Claims Database and take a phased approach. As part of the process:
- Address privacy and security concerns
- Engage stakeholders in planning and establishing parameters
- Establish ground rules for data governance
- Ensure appropriate analytical support to turn data into information and support appropriate use
- Focus on consumer decision support as a first deliverable
- Start with commercial insurer, third-party administrator, Medicaid and Medicare data collection first, then collaborate with other federal payers.

II. 2012 Annual Report

A. Study: Cost of Health Care in Alaska – Pharmaceuticals

Findings

- Prices for pharmaceuticals do not appear to be a significant driver of higher health care costs in Alaska relative to the comparison states of Idaho, Washington, Oregon, Wyoming, and North Dakota.[14]

- Worker's Compensation payment rates for pharmaceuticals are higher in Alaska than the average of the Worker Compensation rates of the five comparison states by approximately 17%.[15]

- Medicare and Medicaid dispensing fees for Alaska are higher than Medicare and Medicaid dispensing fees in all the comparison states.

- There is significant variation in reimbursement levels between payers within Alaska. For example, Medicaid pays 15% more on average than the all-payer average within Alaska, while TRICARE pays 7% less on average.

- Price, while similar in Alaska on average relative to comparison states, and utilization of pharmaceuticals are critically important factors to consider in containing cost growth and improving quality of care and health outcomes.

B. Study: Government Regulation

Findings

- The regulatory environment within which the health care industry operates is significant and complex. Extensive federal, state and local government policies affect such things as licensure and certification of health care workers and facilities, staffing requirements, allowable costs and services, prices for services, ownership and development of facilities, privacy and security of information, and business practices and relationships.

- Government regulation of health care impacts the cost to providers of delivering health care services, the prices paid by purchasers of health care, access to services, and quality and safety of services.

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[14] Milliman, Inc., *Pharmaceutical Reimbursement in Alaska and Comparison States*, October 16, 2012.

[15] Workers' compensation reimbursement for pharmaceuticals is estimated to be 0.4% of total reimbursement by all payers combined based on national prescription drug expenditure data.

- The federal regulatory environment impacting the financing and delivery of health care includes (but is not limited to) the following federal laws and their implementing regulations:
  - SSA – Social Security Act (Medicare and Medicaid laws)
  - PPACA – Patient Protection & Affordable Care Act
  - ARRA/HITECH – American Recovery & Reinvestment Act/Health Information Technology & Clinical Health Act
  - ERISA – Employee Retirement Income Security Act
  - COBRA – Consolidated Omnibus Budget Reconciliation Act
  - HIPAA – Health Insurance Portability and Accountability Act
  - EMTALA – Emergency Medical Treatment and Active Labor Act
  - MHPAEA – Mental Health Parity and Addiction Equity Act
  - ADA – Americans with Disability Act
  - FDA – Food and Drugs Act
  - GINA – Genetic Information Nondiscrimination Act
  - FSHCAA – Federally Supported Health Centers Assistance Act
  - IHCIA – Indian Health Care Improvement Act
  - FTCA – Federal Tort Claims Act
  - Antitrust Laws (including the Sherman, Clayton, and Federal Trade Commission Acts)
  - Tax Laws
  - Labor Laws

- The State regulatory environment impacting the financing and delivery of health care includes (but is not limited to) the State Constitution and laws and regulations addressing:
  - the private insurance market
  - the Medicaid program
  - provider licensure and certification
  - facility certification
  - the Certificate of Need program
  - the Workers' Compensation program
  - public health functions and programs
  - civil legal procedure

- Regulation of the private health insurance market is predominantly a state government function.

  - State of Alaska insurance laws and regulations apply only to the private insurance market. Excluded are:
    - Public insurance programs (Medicare and Medicaid)
    - Federal and tribal health care delivery systems (DOD, VA, Indian Health Service, Tribal Health System)
    - Self-insured employer plans protected under ERISA

  - Approximately 15% of Alaskans are members of private insurance market health plans regulated by the State of Alaska.

  - Two examples of state insurance laws and regulations identified as potential contributors to higher prices for acute medical services in Alaska are:

- A state law that requires payers to reimburse non-contracted providers directly instead of through the patient, removing incentives typically used by payers to encourage providers to join their networks.

- A state regulation requiring usual and customary charge payment to be at least equal to the 80th percentile of charges by geographic area. Since many providers have over 20% of their market share, this implies that those providers can ensure that their charges are below the 80th percentile and therefore, receive payment for their full billed charges

C. Study: Medical Malpractice Reform

Findings

- Alaska's medical malpractice environment is relatively stable, supported by:
  - The 1997 Alaska Tort Reform Act
  - The 2005 Alaska Medical Injury Compensation Reform Act
  - Alaska Civil Rule 82

- Clinicians in two of Alaska's three medical sectors, the Tribal Health System and the Department of Defense/Veterans Affairs, are covered for medical liability under the Federal Tort Claims Act (FTCA) and are not subject to state tort law when acting within the scope of their official duties.

- Alaska's malpractice reforms to-date appear to have made an impact on the cost of medical liability coverage for Alaska's private medical sector.
  - In 1996 medical professional liability rates for physicians in Alaska were approximately two times those in northern California (considered the "gold standard" in liability reform)
  - Today, in 2012, Alaska's medical liability costs are in line with those in northern California.

- Alaskan health care administrators report anecdotally a positive impact on physician recruitment due to the positive malpractice environment in the state.

- Cost savings associated with defensive medicine practices are more difficult to identify because there are other contributors to these practices beyond the threat of litigation. Other factors that may influence defensive medicine practices include physician training and culture, fee-for-service reimbursement structures, and financing mechanisms that insulate patients from the cost of health care services.

D. Strategy: Use telehealth technology to facilitate access to and quality of care

Findings

- Alaskan health care providers have been pioneers and global leaders in the use of telecommunications technologies as a mechanism for enhancing access to health care and improving clinical outcomes.

- Challenges to the continued development and use of telehealth technologies in Alaska include:

  - "Silos" between health care sectors and between payers and providers. There is not a unified approach to identification of telehealth needs, goals, and barriers nor to design of telehealth solutions.
    - Some collaboration has occurred between the military, VA and tribal health system under the auspices of the Alaska Federal Health Care Partnership, but there has been minimal collaboration between the federal and private health care sectors.
    - There has also been some very limited collaboration between payers and providers, e.g., the state Medicaid program and the tribal health system, and certain commercial insurance carriers and private sector hospitals.
    - There has been no collaboration between public and private insurance programs.

  - Misalignment of payment systems between costs and benefits. Savings achieved through the use of telemedicine do not always accrue to the providers who must invest in the technological infrastructure. Reimbursement has been restructured somewhat in recent years to support funding of "presenting" site providers, but there is evidence these reimbursement opportunities are not fully utilized by providers. Questions remain, such as:
    - Are existing reimbursement mechanisms fully utilized, and if not, why not? Is under-billing the result of inadequate documentation by clinicians, insufficient training for coders, or other billing issues?
    - Can new reimbursement mechanisms be justified? Are costs and savings clearly identified and documented?

  - The use of telehealth technology is not coordinated. There are currently multiple telehealth networks operating in Alaska, a variety of equipment and software applications in use, connectivity challenges due to limited bandwidth availability and technological variability, and no consolidated service endpoint index for maintaining the IP (Internet Protocol) addresses of devices used for telehealth purposes.

  - No mechanism for coordinating and scheduling patient encounters with telehealth providers exists.

  - Alaskan licensure is required for out-of-state clinicians serving patients in Alaska. No evidence has been presented that would indicate this poses a significant barrier to telehealth. If it is found to present a significant barrier at some point in the future the question regarding whether the patient-protection function served by state licensure outweighs the telehealth needs would have to be addressed.

- Opportunities exist and recent initiatives are underway that support further development and use of telehealth solutions, including:

  - The Statewide Health Information Exchange (a public-private partnership between the non-profit Alaska eHealth Network and the Alaska Department of Health & Social Services), which is facilitating private, secure communication between health care providers and will implement a platform for the sharing of medical records later this year.

- The Connected Nation Program (in Alaska operating as a public-private partnership between the non-profit Connect Alaska and the Alaska Department of Commerce, Community and Economic Development), which is mapping community broadband access, and working to expand access, adoption and use of high-speed Internet capacity statewide.

Recommendations

1. The Alaska Health Care Commission recommends the Department of Health & Social Services develop collaborative relationships across health care sectors and between payers and providers in existing telehealth initiatives to facilitate solutions to current access barriers. The Commission further recommends telehealth collaboratives:
   - Focus on increasing access to behavioral health and primary care services;
   - Target specific health conditions for which clinical improvement, health outcomes, costs and cost savings can be documented; and,
   - Include an evaluation plan and baseline measurements prior to implementation, measurable objectives and outcomes, and agreement between pilot partners on selected metrics.

2. The Alaska Health Care Commission recommends the Department of Health & Social Services develop a business use analysis for a private sector statewide brokered telehealth service including:
   - Compilation and maintenance of a directory of telehealth providers
   - Compilation and maintenance of a directory of telehealth equipment addresses
   - Coordination of telehealth session scheduling for providers and equipment
   - Facilitation of network connections for telehealth sessions
   - Provision of 24/7 technical support

E. Strategy: Improve patient choice and quality in end-of-life care

Findings

- Any public policy discussion regarding end-of-life care must start with the ethical and spiritual dimension of this issue. Conversations and decisions regarding end-of-life care must be grounded in our common humanity and shared respect for human life.

- Alaskan patients who are seriously or terminally ill sometimes feel they are treated more like a battlefield than a person by the health care system. Quality of end-of-life care can be improved through:
  - Health care programs, practices and standards designed to fully engage patients and their families in understanding and decision-making regarding treatment and service options;
  - Engagement by all Alaskan adults in planning in advance and documenting medical, financial and other legal decisions for end-of-life circumstances.

- Key concepts and definitions important for understanding end-of-life care:

  - "Optimal health is a dynamic balance of physical, emotional, social, spiritual, and intellectual health. Healing involves curing when possible, but embraces more than cure. When illness is limited to disease and health care is limited to cure, the deeper dimensions of healing are missed." Alaska Health Care Commission Definitions

  - "When someone is diagnosed with a disease like cancer, a long journey begins. The disease or illness may be treated and go away. It may go away and come back. In some cases the disease cannot be cured and the patient gets sicker. While a patient's body is treated and cared for to reduce pain and other symptoms, it is also important to care for the whole person at all steps of the disease journey. Palliative care pays attention to the mind, body and spirit of the patient and family. It begins with the diagnosis of a life-limiting disease." Christine DeCourtney, *Palliative Care: Easing the Journey with Care, Comfort and Choices*, 2009

  - "Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice." 73 FR 32204, June 5, 2008

  - Hospice care is palliative care for individuals approaching the end of life and support for family and caregivers through the dying and grieving process. Hospice is neither about slowing nor hastening death, but about providing compassionate care to ease dying, death and bereavement. Most hospice care is provided in the home setting.
    - Hospice began as a movement in the 1970s to advance the philosophy that people have a right to die pain free and with dignity.
    - Nationally, there are now examples of hospice organizations and hospice insurance benefits that support provision of and payment for palliative care for terminally ill patients.
    - Alaska regulations provide for licensing full-service hospices (which are essentially Medicare certified hospices) and volunteer hospices. Volunteer hospices are limited to services they can provide and are prohibited from seeking reimbursement for care.
    - Generally require clinician documentation of life expectancy of six months or less, and does not allow curative treatment to be provided concurrent with hospice care.

- Research demonstrates that palliative care begun at the time of diagnosis of a terminal or serious illness or injury:
  - Improves the patient's experience through decreased pain, discomfort, and psychological distress;
  - Lengthens the patient's life span;
  - Increases patient and family quality of life;
  - Decreases inappropriate use of medical resources and results in cost savings to the health care system;
  - Decreases adverse health outcomes for survivors.

- Health care system cost savings resulting from the use of palliative care and associated services, such as home health care, do not always accrue to the providing organization investing in and potentially subsidizing the services.

- Palliative care is not always reimbursable as a particular service by public and private third-party payers, but certain distinct services provided as a part of palliative care may be reimbursed, such as physician services, hospice services, and home health services. Current reimbursement methodologies do not recognize participation on the palliative care team by other essential providers such as social workers, chaplains, and care coordinators.

- A number of states have implemented or are in the process of developing a statewide POLST Program. Physician Orders for Life-Sustaining Treatment (POLST) (alternately known as Medical Orders for Scope of Treatment (MOST)) is a standardized process designed to improve the quality of care for people who have advanced progressive illness and/or frailty.
  - POLST programs provide tools for translating a patient's health care goals into medical orders. Central components include clarification and communication of patient treatment goals and wishes, documentation in the form of medical orders on a standardized and recognizable form, and an obligation of health care professionals to honor these preferences across all care settings.
  - POLST is not a living will or advanced health care directive. The latter are intended to facilitate planning in advance of a serious illness or injury and to convey wishes in the event the patient is unable to communicate. POLST/MOST is for patients who have been diagnosed with a serious illness and are able to convey their wishes and participate as a partner in their health care team.

- Alaska established the Comfort One Program in state law in 1996 to help health care providers, the Medical Examiner and First Responders identify terminally ill people who have expressed a wish to not receive life-prolonging measures, such as cardiopulmonary resuscitation (CPR), when they go into respiratory or cardiac arrest. Alaska's Comfort One program was based on Montana's Comfort One program, which has evolved in recent years to a POLST program. While Comfort One is primarily intended for communicating patient DNR (Do Not Resuscitate) orders to emergency medical service personnel, POLST applies to all medical providers and conveys patient wishes regarding a broader scope of medical procedures.

Recommendations

1. The Alaska Health Care Commission recommends the Governor or legislature foster communication and education regarding end-of-life planning and health care for seriously and terminally ill patients by supporting a program to:
   a. Sponsor an on-going statewide public education campaign regarding the value of end-of-life planning; and,
   b. Establish and maintain a website for end-of-life planning and palliative care resources, including Alaska-specific information, planning guides, clinical best practices and practice guidelines, and educational opportunities for the general public and for clinicians and other community-based service providers.

2. The Alaska Health Care Commission recommends the Department of Commerce, Community, and Economic Development require within current continuing medical education guidelines education in end-of-life care, palliative care, and pain management for physicians and other state-licensed clinicians as a condition of licensure renewal.

3. The Alaska Health Care Commission recommends the University of Alaska ensure end-of-life care is included within the curriculum of health practitioner training programs.

4. The Alaska Health Care Commission recommends the Department of Health & Social Services fund a process to investigate evolving the Comfort One program to a POLST/MOST program (Physician Orders for Life Sustaining Treatment/Medical Orders for Scope of Treatment).

5. The Alaska Health Care Commission recommends the legislature establish a secure electronic registry aligned with the Statewide Health Information Exchange as a place for Alaskans to securely store directives associated with end-of-life and advanced health care plans online and to give authorized health care providers immediate access to them.

6. The Alaska Health Care Commission recommends the State of Alaska partner with other payers and providers to demonstrate:
    a. The use of telehealth technologies for delivering hospice and other palliative care services to rural and underserved urban Alaskans; and
    b. The design of new reimbursement methodologies that improve the value equation in financing of end-of-life services.

The following Findings & Recommendations regarding the employer's role were superseded in 2013

F. Strategy: Enhance the employer's role in health & health care

Findings

- Employers play an important role in the health of their employees, and in the value – the cost, quality and outcomes – of health care services purchased through employee health plans.

- CEOs who take control of health care like any other supply chain issue and adopt health and health care improvement as a business strategy are improving employee wellness and productivity, containing health care cost growth and improving health care quality for their companies.

- Essential elements of employee health management programs that demonstrate success in driving down health care costs and improving quality and employee health outcomes include:

    - **Price Sensitivity.** Traditional health plans with low deductible and co-payment requirements insulate the plan member/patient from experiencing the direct cost of a service; therefore there is little incentive for the covered patient to engage as an informed consumer and as a partner with their health care provider in addressing questions regarding the need, efficacy and price for a service. Consumer-driven health plans that include employer-supported Health Savings or Health Reimbursement Accounts, off-set by higher deductibles and co-insurance, engage members to shop for price, service and quality, and demonstrate cost savings.

    - **Price & Quality Transparency.** Employees/plan members must have easy access to information on the prices charged for health services, the amount their health plan will reimburse, and the quality of services available in order to be informed and engaged health care consumers.

- **Pro-active Primary Care Emphasis.** Primary care must be easily accessible to employees in terms of physical location and convenience, and also in terms of low or no co-insurance costs. Preventive services, easy access care for acute illness and minor injuries, and pro-active support for management of chronic conditions avoids more costly care that might otherwise require a higher level of care and also higher costs associated with later treatment of conditions that might worsen with time.
- **Support for Healthy Lifestyles.** Employers' policies and working conditions can be designed to support an employee's ability to make healthy choices, and can also provide employees with incentives to improve and maintain their personal health.

Recommendations

2. The Alaska Health Care Commission recommends the Department of Health & Social Services investigate and the legislature support implementation of a mechanism for providing the public with information on prices for health care services offered in the state, including information on how quality and outcomes compare, so Alaskans can make informed choices as engaged consumers.
    - To support this strategy the Commission is currently studying the business use case for a statewide All-Payer Claims Database for Alaska, and investigating health care price and quality transparency legislation enacted in other states.

3. The Alaska Health Care Commission recommends the State of Alaska, as a major employer in the state, play a leadership role for all Alaskan employers by continuing to develop and share strategies already underway to improve employee health and productivity and increase health care value. The Commission recommends the Department of Administration take a comprehensive approach by including all the essential elements of a successful employee health management program: Price sensitivity, price and quality transparency, pro-active primary care, and healthy life-style support for employees.
    - To support this strategy the Commission will continue to engage the business community and public employers in learning about opportunities for increasing value in health care and improving health outcomes.

III. 2011 Annual Report

A. Study: Cost of Health Care in Alaska

Findings

- **Health care spending in Alaska continues to increase faster than the rate of inflation.**
  - Total spending for health care in Alaska reached $7.5 billion in 2010, a 40% increase from 2005. At current trends it is projected to double to more than $14 billion by 2020.
  - By comparison, the wellhead value of oil produced in Alaska was $16.4 billion in 2010, and is projected to be $18.6 billion in 2020.
  - Also by comparison, total wages earned by Alaskan employees was $15.4 billion in 2010.

- **Health care is becoming increasingly unaffordable for U.S. and Alaskan employers and families.**
  - The cost of health insurance premiums in the U.S. increased by 160% between 1999 and 2011, compared to an overall rate of inflation of 38% during that same period.
  - American workers' contributions to health insurance premiums increased 168% between 1999 and 2011, compared to a 50% increase in workers' earnings during that same period.
  - Since 1982 the Anchorage Consumer Price Index increased 95%, while the CPI for medical care in Anchorage over that time period increased 320%.
  - Alaska is number one in the nation for the cost of employee health benefits based on a newly released survey by United Benefits Advisors, which found that Alaska employers are paying an average of $11,926 per employee each year for health insurance – nearly twice as much as the least expensive state.
  - Fewer Alaskan employers are offering employee health benefits in 2010 than in 2003.
    - The percentage of large employers in Alaska (those with more than 50 employees) offering coverage dropped from 95% in 2003 to 93% in 2010.
    - The percentage of small employers offering coverage dropped from 35% to 30% during that same period.
  - Alaskan employees' share in the cost of their insurance premiums increased from 11% to 14% for single coverage and from 17% to 22% for family coverage between 2003 and 2010.
  - The average cost of a health care premium increased 51% for single coverage and 35% for family coverage between 2003 and 2010.
  - The average annual premium cost for family coverage in Alaska was $14,230 in 2010.

- **Cost shifting occurs between commercial and public payers.** Cost per unit of service is significantly higher for commercial payers relative to provider operating costs and compared to the two largest public payers, Medicaid and Medicare. For example, commercial reimbursement rates are 110% higher than Medicare reimbursement for hospital services in Alaska. Also, as spending has increased over time for all payers in Alaska, it increased at a higher rate for individuals and private employers compared to government employers and public programs.
  - Because of the cost shifting that occurs through rate disparities, rate reductions by public payers may result in higher rates charged to commercial insurers and translate into higher premiums for individuals who purchase private insurance and for employers who provide employee health benefits.
  - While the major public payers appear to under-reimburse providers compared to private payers, they provide additional financial support for health care through other mechanisms.

For example, Medicare subsidizes physician residency training, Medicare and Medicaid provide Disproportionate Share Hospital (DSH) payments to hospitals that see a high proportion of Medicare and Medicaid patients, and the federal government through the Indian Health Service and Alaska Tribal Health System has funded much of the development of the rural health infrastructure in Alaska.
    - The existence of public insurance programs helps spread health care system fixed costs among more payers and beneficiaries.

- **Commercial insurance premiums in Alaska are roughly 30% higher relative to five comparison states, which are higher than the national average. Commercial insurance premiums are primarily a factor of utilization and price for health care services.**

- **Alaska's health care utilization rates do not appear to be a major driver behind higher premium rates relative to comparison states based on financial analysis of the private health care system. Utilization of health care services in Alaska is roughly in line with comparison states, and is lower than the nationwide average.**
    - Alaska uses 13% fewer services than the nationwide average to treat a similar Medicare patient.
    - Alaskan Medicare enrollees have fewer hip replacement surgeries and roughly the same number knee and shoulder replacement surgeries (rate per 1,000 enrollees).
    - For the commercially covered population, inpatient bed days are higher overall in Alaska, but lower in urban Alaska than the comparison states. Emergency room visits are higher, outpatient visits are about the same, and medication prescriptions are lower.

- **Health care prices paid in Alaska are significantly higher than in comparison states.**
    - Reimbursement for physician services in Alaska is 60% higher than in comparison states for all payers based on a weighted average; and 69% higher for commercial (private insurance) payers.
    - The difference in reimbursement for physician services varies significantly depending on the specialty. For example, pediatricians in Alaska are reimbursed at rates 43% higher on average than pediatricians in the comparison states, and cardiologists in Alaska are reimbursed at rates 83% higher than cardiologists in the comparison states.
    - Commercial reimbursement for private sector hospital services is 37% higher in Alaska than in the comparison states. Medicare fees paid for private sector hospital services are 36% higher in Alaska than in the comparison states.

- **Medical prices are driven by two components: 1) operating costs associated with delivering medical services, and 2) operating margins. Following are attributes of medical prices in Alaska's private health care sector:**
    - Operating costs for health care providers are higher in Alaska relative to the comparison states. There is insufficient data available to fully analyze and compare physician practice operating costs, but analysis of publicly available hospital cost reports found Alaska private sector hospital operating costs are 38% higher overall and 86% higher for Alaska's private sector rural hospitals. Higher operating costs in Alaska for hospitals and physician practices are driven by:
        - The cost of living, which is 20-30% higher in Alaska than in comparison states (overall, not accounting for rural/urban differences).

        - Medical salaries for health care workers, which are 0% - 10% higher in Alaska (excluding self-employed physicians).
        - Health benefit costs for hospital and physician practice employees, which in Alaska are higher than any other state in the nation.
        - 11% - 15% utilization of "travelling" temporary staff, who typically are paid at a higher rate and whose employment results in other inefficiencies in delivery of health care services;
        - Administrative burdens associated with government regulation and compliance with payer requirements, including documentation requirements, fraud and abuse audits, licensing and certification requirements, and employee background checks.
        - Drivers of higher operating costs in Alaska specific to the private sector hospital system include:
            - RN staffing ratios, which average 29% higher than comparison states.
            - Occupancy rates, which on average are lower at 49.9% in Alaska relative to 58.1% in comparison states.
    - In 2010 the average all-payer operating margin for Alaska's private sector hospital system was 13.4% compared with the average of comparison states' hospital systems of 5.7%. Operating margins for individual Alaska facilities vary widely within these averages, ranging from -9.2% to 29.4%. For Medicare patients, the operating margin is 2.6 percentage points less than the comparison state average, at -11.5% in Alaska compared to -8.9% in the comparison states, causing upward pressure on commercial premiums in order to offset hospital losses.
    - Physician discounts are low in Alaska relative to the comparison states, an indication that physicians in Alaska have more market power relative to pricing.

- **Utilization for health care services in Alaska, while similar to the comparison states and low relative to the U.S. and other industrialized nations, is still a critically important factor to consider in containing cost growth and improving quality of care and health outcomes.** Utilization of health care resources is highly inefficient. The estimated level of wasted health care spending in the U.S. is between 30% and 50%, leaving significant room for improvement in the effectiveness and efficiency of health care delivery.

- **Market forces affecting pricing for health care services are impacted by state laws and regulations in Alaska.** There are state laws and regulations in place that influence the market in such a way as to drive prices higher for the consumer.
    - Lower physician discounts in Alaska can be at least partly explained by the relative lack of competition among providers, particularly for specialty care. In many areas, including Anchorage, there are a limited number of providers in any given specialty (sometimes only one provider group). As a result, physicians can largely dictate the fees they are paid by commercial payers.
    - Relative provider leverage may be further exacerbated by Alaska's regulation requiring usual and customary charge payment to be at least equal to the 80th percentile of charges by geographic area. Since many providers have over 20% of their market share, this implies that those providers can ensure that their charges are below the 80th percentile and therefore, receive payment for their full billed charges.

- A separate state law requires payers to reimburse non-contracted providers directly instead of through the patient, removing incentives typically used by payers to encourage providers to join their networks.

- **The average payment for durable medical equipment (DME) in Alaska is 21% higher for all payers relative to the average comparison state payment level.** DME consists of non-pharmaceutical items ordered by a provider for a patient. By payer, the average reimbursement for DME is:
  - 23% higher for commercial payers in Alaska relative to the average across commercial payers in the comparison states
  - The same in Alaska for Medicare and TRICARE as the comparison states' Medicare and TRICARE average
  - 180% higher for the VA in Alaska relative to the average VA payment across the comparison states
  - 55% higher for the Alaska Medicaid program relative to the average Medicaid program payment across the comparison states (excluding N. Dakota)
  - 98% higher for the Alaska Workers' Compensation program relative to the average of N. Dakota and Washington states' Workers' Comp payment level (Idaho, Oregon and Wyoming not available)

B. Strategy: Patient-Centric Primary Care

Findings

- Strong primary care systems are foundational to a high performing health care system. Improving access to primary care that is patient-centric and enhancing the role of primary care providers in the coordination and management of care improves health and lowers the per capita cost of health care.

- Improved evidenced-based care management, especially of patients with complex health conditions experiencing high needs and high costs, can reduce health care costs while improving patient care and outcomes.

- A renewed emphasis on the value of primary care and new models of primary care practice are borne out of a convergence in the progression of medicine and changes in patient needs.
  - The vast increase in medical knowledge over the past several decades has led to more complexity in the management of medical information and also increased specialization of medical practitioners.
  - Improvements in the prevention and control of infectious disease and injury have been accompanied by a higher prevalence of chronic disease in the population, which has led to a shift in patient care needs from acute episodic care to chronic care management.

- Changes in medicine and patient needs necessitate a stronger role for primary care providers in supporting patients with the navigation of medical information, coordination of care between specialists, and management of chronic health conditions. Primary care practitioners who have fully assumed these expanded responsibilities have demonstrated cost savings for the overall health care system and improved health status of their patients; however, traditional fee-for-service payment

models do not adequately recognize the new functions and do not adequately compensate primary care providers for the additional work involved.

- Patient-centered primary care requires:

    - a continuous healing relationship between the clinical team and the patient; ensuring patients and their families have the information, skills and tools necessary to maintain and manage their health, and that they are treated in a way that is respectful, engaging and empowering.

    - a holistic approach to patient care that views the patient as a whole person, acknowledging and understanding behavioral as well as physical health needs, and integrating primary care for behavioral and physical conditions in a common clinical setting.

    - an active partnership between the primary care provider, community health and social service providers, and governmental public health agencies to effectively coordinate and manage the care of patients with complex health conditions and to support primary prevention for healthy patients.

- Innovative approaches to strengthening primary care and making it more patient-centric have been implemented and are being tested in many other states, by the Veteran's Administration and the Department of Defense, and here at home within the Alaska Tribal Health System. A number of these innovative programs are demonstrating that it is possible to improve care for patients, improve health outcomes for the patient population, and reduce health care costs for the payers. Some are beginning to move forward with multi-payer initiatives to drive further transformation of their health care systems. The design of pilot programs under development in Alaska can be informed by lessons learned from the experience of these early innovators, such as:
    - Community Care of North Carolina (CCNC), whose demonstrated cost savings and improvement in patient outcomes include:
        - Annual growth in Medicaid expenditures fell from a high of 11.5% in 2002 to 2.5% in 2010;
        - Total Medicaid savings of $1.5 billion between 2006 and 2010;
        - Scores in the top 10% in the nation on key quality measures related to care for diabetes, asthma, and heart disease.
        - Comparison of Medicaid Aged, Blind and Disabled members enrolled in CCNC to members not enrolled in the program demonstrated between 2007 and 2010:
            - Better access to care - 95.9% of enrollees use health care system compared to 86.5% of unenrolled population.
            - Average spending for inpatient hospital services decreased 6%, compared to a 25% increase for the unenrolled population.
            - Potentially preventable inpatient admissions declined by 12.5%, while increasing by 25.9% for the unenrolled.

    - Blue Cross Blue Shield of Michigan, which administers the largest patient-centered medical home (PCMH) program in the country with 2,500 physicians in 700 PCMH-designated practices, demonstrated in 2010 that PCMH practices had a
        - 7% lower rate of pediatric emergency room visits;

        - 25.5% lower rate of adult inpatient admissions among patients with manageable chronic conditions; and
        - 7.4% lower rate of adult high-tech radiology usage.

    - CareOregon, a non-profit Medicaid managed care plan in Oregon which piloted their Primary Care Renewal (PCR) program in 2007 and has been expanding it since. Results from the pilot test include a:
        - 7.6% increase in proportion of diabetic patients with blood sugar under control, and of hypertensive patients with blood pressure under control
        - Threefold increase in proportion of patients screened for depression
        - 9% decrease in average cost for dual eligible members (plan members enrolled in both Medicaid and Medicare) treated at a PCR site, compared to a 1.2% increase for those treated in non-PCR sites.

    - The Veterans Health Administration launched a three year plan in April 2010 to transition more than 900 primary care clinics across the country to patient-centered medical homes, investing more than $227 million to hire additional clinical staff, institute a nationwide training program, and develop regional learning collaboratives. In one year a sample clinic increased access to same-day appointments for veterans who previously had to wait as long as 3 months, reduced inappropriate emergency department visits from 52% to 12%, and improved blood sugar scores in 33% of patients with poorly controlled diabetes.

    - Within the Department of Defense all three service branches are moving towards a medical home model of care in their military treatment facilities and is collaborating with TRICARE Management and the VA. The DOD and VA are working together on development of guidelines for evidence-based practices critical to the functioning of a medical home, and also on design of quality metrics and process evaluations.

- There is currently active interest and engagement in the development of patient-centered primary care models in Alaska on the part of health care payers and primary care providers.

    - The Alaska Medicaid Task Force, convened Sept 2010 – April 2011 to identify cost containment strategies, recommended that the state's Medicaid program pilot test patient-centered medical home. DHSS plans to contract with a consultant during SFY 2012 to assist with the design of the pilot program.

    - The Alaska Primary Care Association received a $400,000 capital grant from the state legislature this year to assist community health centers with transition to a medical home model.

    - The Alaska Native Tribal Health Consortium is supporting a collaborative of clinicians throughout the tribal health system in an Improving Patient Care initiative that includes testing and learning from patient-centered medical home projects.

    - Two primary care clinics in Alaska currently hold NCQA (National Committee for Quality Assurance) recognition as Patient Centered Medical Homes – the Southcentral Foundation (SCF) Primary Care Center (Level 3), and the Providence Family Medicine Center/Alaska Family Medicine Residency Program (Level 1).

- Numerous private sector primary care clinics are actively working on implementing various aspects of the PCMH model, such as opening up schedules for same-day appointments, establishing or upgrading electronic medical records systems, and creating web-based patient information portals. The commission specifically learned about the efforts of the Tanana Valley Clinic in Fairbanks and Medical Park Family Care in Anchorage.

- The state Department of Health & Social Services is participating in a multi-state collaborative ("TCHIC") funded by CMS to test quality measurement and health information technology applications to improve care for children in Medicaid. DHSS created a medical home pilot program under this initiative this year and awarded pilot-site grants to Central Peninsula Community Health Center (Kenai/Soldotna), Iliuliuk Family & Health Services (Unalaska), and SCF (Anchorage).

- A number of clinics are working to integrate primary care and behavioral health services. Two organizations, Alaska Island Community Services (Wrangell) and SCF (Anchorage) received federal demonstration grants this year to introduce primary care services within behavioral health clinic settings.

Recommendations

1. The Alaska Health Care Commission recommends the State of Alaska recognize the value of a strong patient-centered primary care system by supporting appropriate reimbursement for primary care services.

2. The Alaska Health Care Commission recommends the State of Alaska support state policies that promote the central tenet of patient-centered primary care – that it is a model of care based on a continuous healing relationship between the clinical team and the patient.

3. The Alaska Health Care Commission recommends the State of Alaska and other entities planning a patient-centered primary care transformation initiative incorporate the following strategies the Commission found to be common to start-up of successful programs studied as models. These successful models started with:
   a) Financial investment by the initiating payer organization (whether public or private).
   b) Strong medical leadership and management involved in planning and development.
   c) A collaborative partnership between the payers and clinical providers.
   d) A vision concerned with improving patient care, followed by identification of principles, definitions, criteria for participation, and tools and measures.
   e) A focus on local (i.e., practice-level) flexibility and empowerment.
   f) A phased approach to implementation.
   g) A tiered approach to managing patient populations.

4. The Alaska Health Care Commission recommends the State of Alaska and other entities implementing a patient-centered primary care transformation initiative include the following attributes the Commission found to be common to successful programs studied as models:

a) **Resources** provided to primary care practices to support improved access and care coordination capabilities.
b) **New tools and skill development opportunities** provided to primary care practices to support culture and practice transformation.
c) **Shared learning environments** for clinical teams to support development of emergent knowledge through practice and dissemination of new knowledge.
d) **Timely data** provided to primary care practices to support patient population management and clinical quality improvement, including centralized analytical and reporting capability and capacity.
e) **Infrastructure support** for medical guidance, including a medical director for clinical management and improvement, case managers, pharmacists, and behavioral health clinicians.
f) **A system of review** that includes both implementation monitoring by initiative partners and evaluation of initiative outcomes by an independent third-party.

5. The Alaska Health Care Commission recommends the State of Alaska support a patient-centered medical home (PCMH) initiative, recognizing:
   a) Front-end investment will be required for implementation, and it may take two to three years before a return on investment will be realized;
   b) Collaboration between State programs that pay for health care, other health care payers and the primary care clinicians who will be responsible for implementing this model is essential to success; and,
   c) Patient-centered primary care development is not the magic bullet for health care reform, but is an essential element in transforming Alaska's health care system so that it better serves patients, better supports providers, and delivers better value.

The following Findings & Recommendations regarding the employer's role were superseded in 2013

C. Strategy: Price & Quality Transparency

Findings

- There currently is insufficient data and information to support consumerism in Alaska's health care market. Empowering consumers and health care providers with access to information on the cost and quality of care is an important strategy for improving value in Alaska's health care system.

- Some patients lack incentives to seek value in their health care decisions. Normal supply-and-demand price mechanisms do not always work when consumers are insulated from the cost of a good or service, which is one effect of the third-party payer health insurance system. Consumers who share directly in the out-of-pocket cost of their health care purchases are more likely to make decisions based on value (price and quality).

- State government and other payers require high quality health data sources and health analytics capacity to provide the information needed to guide payment reform and health care delivery improvement policies.

- Alaska's Hospital Discharge Database is an important source of health care data, and is a good example of collaboration between a health care provider group and the State to make health care data more transparent. However, this data set is currently incomplete due to lack of full participation by all of Alaska's hospitals. It is also insufficient for supporting full cost and quality transparency in that it represents care provided only by acute care hospitals.

- A number of states have implemented or are in the process of planning for All-Payers Claims Databases (APCDs) to complement data from their Hospital Discharge Data and Medicaid Management Information Systems. APCDs are large-scale databases that systematically collect and aggregate medical, dental and pharmacy claims data from public and private payers, and are valuable sources of information about outpatient services and health care payments for those states that have implemented them. They also minimize the burden on health care providers as the aggregated data from payers is an efficient alternative to collecting data directly from individual providers.

Recommendations

1. The Alaska Health Care Commission recommends the State of Alaska encourage full participation in the Hospital Discharge Database by Alaska's hospitals.
2. The Alaska Health Care Commission recommends the State of Alaska study the need for and feasibility of an All-Payers Claims Database.

D. Strategy: Payment Reform – Paying for Value, Rather than Volume

Findings

- Current fee-for-service and third-party payment structures reward delivery of high numbers of costly services; compel health care to be technology driven, volume-driven, fragmented, and expensive; and are a disincentive to innovations that improve health outcomes and the efficiency and effectiveness of health care services.

- There are options to health care cost containment strategies that do not rely on across-the-board rate reductions, price controls and rationing. These alternative approaches attempt to maximize value by moving away from payment for individual services to payment structures that reimburse providers for high quality care and improved health outcomes.

- Improving value in health care requires the following four mutually supportive components:
  1. **Consumer Empowerment**
     a. Educational materials and tools
     b. Engagement strategies that recognize the consumer as a partner/owner in their care
  2. **Price and Quality Reporting & Measurement**
     a. Measurement and analytics system design
     b. Reporting on quality, cost and experience of care
  3. **Value-Driven Health Care Delivery**, which empowers the patient and focuses first on keeping the patient healthy, minimizing the need for hospital care when health is compromised, and ensuring efficient successful outcomes when care is required.

a. Design and delivery of care grounded in evidence-based medicine principles
b. Technical assistance to providers
c. Provider organization coordination

4. **Value-Driven Payment Systems and Benefit Designs**.
    a. Payment system design
    b. Benefit design grounded in evidenced-based medicine principles
    c. Engagement of Purchasers
    d. Alignment of multiple payers

- Successful payment reform initiatives require systems that can support:
    - Capabilities to **manage financial risk** for payers and providers
        - Data and analytics for monitoring utilization and quality
        - Actuarial expertise for financial risk analyses
    - Capabilities to **manage health** for patients, providers, payers
        - Methods for targeting high risk patients
        - Capability to track, coordinate and follow-up on patient care
        - Patient education and self-management support
    - **Alignment of organizational structures** among providers
        - Trust relationships between physicians and hospitals
        - Significant regulatory barriers exist
        - Neutral, trusted facilitator may be required
    - **Alignment of payment policies** among payers
        - Multi-payer approaches to avoid further fragmentation of payment systems

- 26 cents of every health care dollar spent in Alaska are public funds administered either directly or indirectly by the State of Alaska, including state and federal Medicaid funds and spending for state employee and retiree health benefit s, correctional system inmates' care, workers' compensation, and other state health care programs. State government holds significant purchasing power that could be utilized to leverage improvement in Alaska's health care system.

Recommendations

1. The Alaska Health Care Commission recommends the State of Alaska utilize payment policies for improving the value of health care spending – for driving improved quality, efficiency and outcomes for each health care dollar spent in Alaska – recognizing that:
    a. Local payment reform solutions are required for Alaska's health care markets
    b. Payment reform may not result in immediate cost savings, but efforts must begin immediately
    c. Payment reform is not the magic bullet for health care reform, but is one essential element in transforming Alaska's health care system so that it better serves patients, and delivers better value for payers and purchasers.

2. The Alaska Health Care Commission recommends the State of Alaska take a phased approach to payment reform, revising payment structures to support primary care transformation as a first step in utilizing payment policies for improving value in Alaska's health care system.

3. The Alaska Health Care Commission recommends the State of Alaska develop health data collection and analysis capacity as a tool for quality improvement and payment reform. Data collection, analysis and use decisions should involve clinicians, payers, and patients.

4. The Alaska Health Care Commission recommends the State of Alaska support efforts by state officials responsible for purchasing health care services with public funds to collaborate on the development of common purchasing policies. These collaborative efforts should include key stakeholders, and should be used as leverage to drive improved quality, effectiveness, efficiency and cost of care in Alaska's health care system. These efforts should endeavor to engage commercial payers and federal health care programs in alignment of payment policies in a multi-payer approach to minimize the burden on health care providers.

E. Strategy: Alaska's Trauma System

Findings

- Injury is the leading cause of death for Alaskans who are one to 44 years of age. Roughly 400 to 500 Alaskans die each year as the result of an injury. Approximately 5,000 Alaskans are admitted to a hospital each year due to an injury, over 1,000 of who are left with a permanent disability.

- A trauma system that provides rapid, effective, and efficient response and treatment is critical to reducing death and disability due to injury. An improved trauma system improves overall care for any health condition that is time critical, such as heart attack and stroke, not just trauma.

- The Alaska Department of Health & Social Services made trauma system improvement a priority three years ago with the commission of a study by the American College of Surgeons Committee on Trauma. Subsequently the Division of Public Health began implementing the ACS recommendations for strengthening Alaska's trauma system by establishing a Trauma System Coordinator position to support development of a trauma system strategic plan, and reorganizing to consolidate the Emergency Medical Services Program with the Emergency and Disaster Preparedness Program. More recently the Division has invested in improving the Alaska Trauma Registry to ensure sound data is available for informing prevention and system improvement efforts.

- The Alaska Legislature made a commitment to strengthening Alaska's trauma system, passing a bill during the 2010 legislative session establishing the Uncompensated Trauma Care Fund to incentivize hospitals to meet trauma center standards.

- Alaska's health care community has made commitments to strengthening Alaska's trauma system. The Alaska Native Medical Center has demonstrated leadership in trauma care in Alaska for many years and is currently the only Level II designated trauma center in the state, the highest level any hospital in Alaska can attain. Four of Alaska's rural hospitals are designated Level IV trauma centers. An additional nine hospitals are actively working towards

attainment of trauma center designation. However, Alaska remains the only state in the nation without a Level II or higher designated trauma center serving the general population.

Recommendations

- The Alaska Health Care Commission recommends the State of Alaska support a strong trauma system for Alaska that:
    - Is comprehensive and coordinated, including:
        - Public health system capacity for
            - studying the burden of injury in the local population
            - designing and implementing injury prevention programs
            - supporting the development and exercise of local and statewide emergency preparedness and response plans
        - Emergency medical service capacity for effective pre-hospital care for triage, stabilization and coordination of safe transportation of critically injured patients
        - Trauma center care for treatment of critically injured patients
        - Rehabilitation services for optimizing recovery from injuries
        - Disability services to support life management for individuals left with a permanent disability due to an injury
    - Is integrated, aligning existing resources to efficiently and effectively achieve improved patient outcomes.
    - Is designed to meet the unique requirements of the population served.
    - Provides evidence-based medical care to achieve the best possible outcomes for the patient.
    - Provides seamless transition for the patient between the different phases of care.

- The Alaska Health Care Commission recommends the State of Alaska support continued implementation of the recommendations contained in the 2008 consultation report by the American College of Surgeons Committee on Trauma, including achievement and maintenance of certification of trauma center status of Alaskan hospitals.

F. Strategy: Obesity in Alaska

Findings

- The growing prevalence of overweight and obese Alaskans is the most significant public health challenge facing Alaska today. This largely avoidable condition affects Alaskans of all ages, from all regions, across all levels of education and income, and of all racial and ethnic backgrounds. The dramatic increase in overweight and obesity prevalence that occurred over the past 18 years will have lasting financial and health impacts on Alaskan families, communities, businesses, and the health care system for decades to come.

- Overweight and obesity cause 365,000 premature deaths a year in the U.S.

- Medical spending in the U.S. directly related to overweight and obesity was estimated at $147 billion annually in 2008, and $477 million in Alaska.

- As many as 40% of Alaska's children are overweight or obese.

- The generation of Americans born in the last decade may be the first generation of Americans who do not live as long as their parents, since our country began, due to the medical complications of overweight and obesity. A child born today has a 34-38% chance of developing diabetes in his or her lifetime.

Recommendations

- The Alaska Health Care Commission recommends the State of Alaska implement evidence-based programs to address the growing rate of Alaskans who are overweight or obese. First efforts should focus on nutrition and physical activity for children and young people and raise public awareness of the health risks associated with being overweight and obese.

G. Strategy: Immunization against Vaccine-Preventable Disease

Findings

- Until the mid-20th century infectious diseases were a leading cause of illness, disability and death in Alaska. Few effective treatment and preventive measures existed. Since that time there has been a dramatic decline in the burden of infectious disease in the population due to significant achievements in control measures, especially for those diseases for which vaccines have been developed.

- During the 20th century the success of biomedical science in development of vaccines combined with the success of the public health system in immunizing the population led to the eradication of smallpox from the worldwide population and the elimination of polio from the U.S. population. Furthermore, immunizations have resulted in substantial declines in other diseases that had previously been a common cause of serious illness and death among children, such as measles, mumps, rubella, diphtheria, tetanus, pertussis, and bacterial meningitis.

- Despite remarkable progress in vaccine development and use, there are a number of challenges in maintaining sufficient immunization levels to protect the population.
  - Vaccination schedules have become increasingly complex. U.S. children require 19 doses of vaccine by age 35 months to be protected against 11 childhood diseases.
  - The success of immunization policies in controlling once-dreaded diseases has led to complacency among some subsets of the population toward vaccines.
  - Insufficient and erroneous information about vaccine safety and effectiveness creates confusion among parents, who must recognize immunizations as an important tool in protecting their children's health and actively seek them.
  - Health care providers must be kept informed of the latest developments and recommendations.
  - Vaccine supplies and financing must be made more secure.

- Researchers must address increasingly more complex questions about safety, efficacy, indications, contraindications, and delivery.
- Information technology must be used to support timely vaccination.
- Adolescents and adults must be targeted for vaccine-preventable diseases that affect their age groups, such as influenza and pneumonia.

- Alaska's childhood immunization rate has declined in recent years to nearly the lowest in the nation. Alaska's rate of immunization completion for children ages 19 months to 35 months was just 56.6% in 2009, compared to the national average of 70.5%, ranking Alaska 49th among the 50 states and leaving Alaska's children vulnerable to preventable diseases that can result in serious complications, preventable hospitalizations, and in some cases death.

- The Alaska Division of Public Health, Department of Health & Social Services, maintained a "universal vaccine program" (providing all recommended childhood and adult vaccines to public and private health care providers in the state) for over three decades. The vaccine program was supported almost entirely with federal funding from two different sources, one of which is reducing its annual allocation to Alaska by $3.6 million in a phased 3-year reduction starting in FFY 11.
  - As a result of the loss of funding the state discontinued provision of all adult vaccine and of human papillomavirus and meningococcal vaccines for children in FFY 11, and will no longer provide the following childhood vaccines for children who are not eligible for the Vaccines for Children Program ("VFC"; a program for children who are American Indian/Alaska Native, on Medicaid, or uninsured) beginning in FFY 12: influenza, pneumococcal conjugate, and rotavirus.
  - Elimination of the universal vaccine program is expected to have the following consequences:
    - Reduction in the number of small private medical practices that provide vaccine to their patients due to the complexities of maintaining separate vaccine supplies (per VFC administrative requirements), and the cost of up-front purchase of expensive vaccine;
    - Reduced immunization coverage leading to increased risk of vaccine-preventable diseases such as measles, mumps, pertussis, chicken pox and hepatitis A; and,
    - Inability to maintain a stockpile of vaccine to support timely response to outbreaks of vaccine-preventable disease.

Recommendations

- The Alaska Health Care Commission recommends the State of Alaska ensure the state's immunization program is adequately funded and supported, and that health care providers give priority to improving immunization rates in order to protect Alaskans from serious preventable diseases and their complications.

H. Strategy: Population-Based Prevention & Behavioral Health

Findings

- Behavioral health is essential to whole health. Almost one-quarter of all adult stays in U.S. community hospitals involve mental or substance use disorders. 83% of people diagnosed with serious mental illness are overweight or obese. The life span of a person with SMI is 27 years shorter than the average life span.

- Alaskans experience high rates of violence. According to the 2010 Alaska Victimization Study, 47.6% of adult women in Alaska experienced intimate partner violence in their lifetime. 37% experienced sexual violence, and 27% experienced alcohol or drug involved sexual assault.

- Adverse childhood experiences, such as recurrent and severe physical or emotional abuse, sexual abuse, or growing up in a household with an alcoholic or drug user, a member in prison, a mentally ill member, a mother treated violently, or both biological parents absent, are a significant determinant of health and well-being well into adulthood, correlating to poor health indicators such as obesity and depression.

- Binge alcohol use in Alaska is among the highest in the nation. 8% of all adults in Alaska, 20% of adults ages 18-25, and 25% of students in grades 10, 11, and 12 use marijuana.

- Alcohol use is suspected or proven in nearly 25% of all hospitalizations for injury.

- In 2009 the age-adjusted suicide rate for all Alaskans was 20.2/100,000 (140 lives lost). The suicide rate among Alaska Native people is two times that of non-Native.

- Routine screening for substance abuse, depression, and a history of adverse childhood events using evidence-based tools is an important strategy for reducing the prevalence of health conditions related to these problems.

- Integration of primary care for both behavioral and physical conditions in a common clinical setting is an essential feature of patient-centered primary care.

Recommendations

- The Alaska Health Care Commission recommends the State of Alaska support efforts to foster development of patient centered primary care models in Alaska that:
  - Integrate behavioral health services with primary physical health care services in common settings appropriate to the patient population.
  - Assure coordination between primary care and higher level behavioral health services.
  - Include screening for the patient population using evidence-based tools to screen for
    - A history of adverse childhood events
    - Substance abuse
    - Depression

- The Alaska Health Care Commission recommends the State of Alaska develop with input from health care providers new payment methodologies for state-supported behavioral health services to facilitate integration of primary physical health care services with behavioral health care services.

IV. 2010 Annual Report

The following Findings & Recommendations regarding evidence-based medicine were superseded in 2013

A. Foster the use of Evidence-Based Medicine

Findings:

A: Waste in the health care system due to misused medical resources is estimated to represent as much as 30% of health care spending.

B: Evidence-based medicine can increase the effectiveness of medical treatment, improve the quality of health care, and reduce health care costs.

C: Public and private health care sectors have demonstrated an increasing interest in applying evidence-based medicine to policy and practice in response to high and rising costs and variations in quality of health care.

D: Involvement of health care providers and patients in decision-making is essential to the successful application of evidence-based medicine to clinical practice and public and private payer policies.

E: Existing mechanisms to assess patients' compliance with evidence-based medical recommendations are limited.

F: Assessing the outcomes of health care interventions is challenging due to limitations on collecting and sharing data among patients, clinicians, payers, and government agencies.

Recommendations:

A: The Commission recommends that the Governor and Alaska Legislature encourage and support State health care programs to engage in the application of high grade evidence-based medicine in making determinations about benefit design (covered services, prior authorization requirements, patient cost-sharing differentials) and provider payment methods.

B: The Commission recommends that the Governor require State health care programs to coordinate development and application of evidence-based medicine policies to create a consistent approach to supporting improved quality and efficiency in Alaska's health care system

C: The Commission recommends that the Governor require State health care programs to involve health care providers and consumers in decision making related to the application of evidence-based medicine to public policy. The purpose of such involvement is to support a transparent process leading to policies that avoid restricting access to appropriate treatment and that foster informed discussions

between patients and clinicians in which individualized, evidence-based choices improve the quality of health care.

D: The Commission recommends that the Governor direct State health care programs to seek to incorporate data on patient compliance in developing new provider payment methods and benefit design.

E: The Commission recommends that the Alaska Department of Health & Social Services implement a web-based data system for public health information.

V. 2009 Annual Report

A. The Role of Consumers in Health Care

1. Healthy Lifestyles

Findings:

A1a: Chronic disease is the leading cause of death and disability in the U.S. and Alaska.

A1b: The majority of health care spending in the U.S. is for chronic disease.

A1c: Three risk factors – tobacco use, poor diet and inactivity – contribute to the four leading chronic diseases – heart disease, diabetes, lung disease and cancer.

A1d: Individual behavior is now the leading determinant of the health status of the population and contributor to premature death.

A1e: Childhood obesity is a growing concern; for example, 33% of kindergarten and 1st grade students in the Anchorage School District are overweight or obese.

A1f: Employee health risk behaviors can be changed through financial incentives coupled with other supports (e.g., coaching).

Recommendations:

A1a: The Commission recommends that the Governor and Alaska Legislature investigate and support additional strategies to encourage and support healthy lifestyles, including strategies to create cultures of wellness in any setting.

A1b: The Commission recommends that the 2010 Alaska Health Care Commission continue evaluating the question of what works to support behavior change, and identify additional recommendations for future improvement.

2. Primary Care Innovation

Findings:

A2a: Patient-centric health care delivery models based on a longitudinal relationship-based platform are effective at reducing unnecessary utilization of services by empowering patients to take more responsibility for their health and health care.

Recommendations:

A2a: The Commission recommends that the Governor and Alaska Legislature aggressively pursue development of patient-centric care models through payment reform, removal of statutory and

regulatory barriers, and implementation of pilot projects. Development of pilot projects should include definition of the patient-centric model, identification of performance standards and measures, and payment models that are outcome-based.

B. Statewide Leadership

1. Response to National Health Care Reform

Finding

B1a: National health care reform proposals under consideration by Congress will have a significant impact on Alaska's state and local governments, health care system, business community, citizens, and families.

Recommendation

B1a: The Commission recommends that the Governor and Alaska Legislature invest in the state health policy infrastructure required to study, understand, and make recommendations to respond to the implications of national health care reform for Alaska.

2. Permanent State Health Planning Board

Finding:

B2a: The systems and policies for financing and delivering health care in Alaska are fragmented and complex, and the scope of the challenges involved in improving these systems is huge. Past efforts to improve health care in Alaska have been ad hoc in nature. A planning process to achieve health care system improvement must be sustained over time in order to ensure accountability for the achievement of meaningful change.

Recommendation:

B2a: The Commission recommends that the Alaska Legislature establish an Alaska Health Care Commission in statute, similar in size to the Commission established under Administrative Order #246, to provide a focal point for sustained and comprehensive planning and policy recommendations for health care delivery and financing reform, and to ensure transparency and accountability for the public in the process.

C. Health Workforce Development

Findings:

C1a: Health care in Alaska is big business and represents a significant employment sector.

C1b: Access to health care requires a sufficient supply and adequate distribution of health care providers. Successful achievement of the goal of expanding access to health care in Alaska is directly tied to health care workforce capacity and capability.

C1c: Health care worker shortages in Alaska are widespread and costly.

C1d: A comprehensive approach to health care workforce training includes strategies at every point on the training continuum (K12, post-secondary, graduate and post-graduate, on-the-job, continuing medical education).

C1e: Alaskans have been particularly innovative in meeting their health care workforce needs.

C1f: Many organizations, both public and private, have a stake in health care workforce development, and there are numerous programs and groups currently involved in health care workforce planning. There is evidence of collaboration in these planning and development efforts; however, not all related activities are fully coordinated.

Recommendations:

C1a: The Commission recommends that the Governor and Alaska Legislature maintain health care workforce development as a priority on Alaska's health care reform and economic development agendas.
C1b: The Commission recommends that the Governor and Alaska Legislature explore strategies for strengthening the pipeline of potential future Alaska health care workers.

C1c: The Commission recommends that the Governor and Alaska Legislature explore strategies for ensuring Alaska's health care workforce continues to be innovative and adaptive, and that it is responsive to emerging patient care models.

C1d: The Commission recommends that the Governor designate a single entity with the responsibility for coordinating all health care workforce development planning activities in and for Alaska. Coordination and collaboration of funders, policymakers and stakeholders in workforce planning and development efforts should be encouraged to the greatest extent possible.

C1e: The Commission recommends that the 2010 Alaska Health Care Commission continue studying health care workforce needs in coordination with other organizations and coalitions addressing this issue, and identify recommendations for additional improvements.

1. Physician Shortage

Findings:

C2a: The United States is facing a shortage of physicians as this provider population ages and enters retirement and the production is not expected to keep up with demand. As the physician shortage increases in the U.S. the competition for recruiting physicians to Alaska will become increasingly difficult.

C2b: Alaska has a shortage of primary care physicians[16].

C2c: New physicians face disincentives to entering primary care specialties.
C2d: Providers stay to practice where they train.

C2e: Mid-level medical practitioners (Nurse Practitioners and Physician's Assistants) and medical support staff (nurses, medical assistants, care coordinators, etc.) are essential occupations for addressing primary care physician shortages.

Recommendations:

C2a: The Commission recommends that the Governor and Alaska Legislature target the state's limited financial resources invested in physician workforce development to strengthening the supply of primary care physicians.

C2b: The Commission recommends that the Governor and Alaska Legislature support development and maintenance of an educational loan repayment and direct financial incentive program in support of recruitment and retention of primary care physicians and mid-level practitioners.[17]

C2c: The Commission recommends that the Governor and Alaska Legislature support the continued expansion of the WWAMI program. Future expansion should be supported as resources allow.

C2d: The Commission recommends that the Governor and Alaska Legislature support graduate medical education for primary care and behavioral medicine. State financial support should continue for on-going operation of the Alaska Family Medicine Residency Program, and should be appropriated for the planning and development of in-state residency programs for pediatrics, psychiatry, and primary care internal medicine.

C2e: The Commission recommends that the Governor and Alaska Legislature ask Alaska's congressional delegation to pursue federal policies to address equity in the allocation and distribution of Medicare Graduate Medical Education (GME) residency slots. The exclusion of new programs is not equitable, and there should be heavier weighting for primary care GME and for shortage areas.

C2f: The Commission recommends that the Governor and Alaska Legislature explore strategies for improving the primary care delivery model and utilizing "physician extender" occupations as an additional approach to addressing the primary care physician shortage.

[16] The Commission includes both osteopathic as well as allopathic medical doctors in their definition of physician. The Commission's definition of primary care physician is slightly different from most standard definitions – family practitioners, pediatricians, and general internists are included, but also psychiatrists, and Ob-Gyns are excluded.
[17] The Commission's recommendation that an educational loan repayment and direct incentive program be established for Alaska to assist with addressing physician shortage specifically is not meant to exclude other provider types for which shortages are documented from such a program.

D. Health Information Technology

1. General HIT Findings & Recommendations

Finding:

D1a: Development and utilization of electronic information management tools is essential to health care system improvement for the purpose of supporting:

- Increased health care efficiency and effectiveness; and
- Improved clinical quality and patient safety.

Recommendation:

D1a: The Commission recommends that the Governor and Alaska Legislature take an aggressive approach to supporting adoption, utilization, and potential funding of health information technology, including health information exchange, electronic health records and telemedicine/telehealth that promise to increase efficiency and protect privacy.

2. Health Information Exchange and Electronic Health Records

Findings:

D2a: Many providers in Alaska are at the early end of adopting electronic health records. Many still use paper records. Barriers to adoption of electronic health information technologies by Alaska's health care providers include:

- Start-up costs for new systems, including purchase of new hardware and software as well as costs associated with implementing new office procedures, training staff, and transitioning existing records from paper to electronic;
- The multitude of products on the market making evaluation and selection of one system time-consuming and costly for individual providers and small practices;
- Systems that are not user-friendly from the provider's perspective, i.e. are difficult, inflexible and time-consuming to use;
- Costs associated with on-going operation and maintenance; and,
- Antiquated and nonstandard eligibility and claims processing systems.

D2b: Federal policies, such as the national incentive program funded under ARRA and pending Medicare payment penalties, are forcing rapid adoption of electronic health records **by providers.** Some Alaskan providers feel forced to move forward quickly while being concerned that standards are not yet fully in place and systems may not be ready.

D2c: Alaskans are concerned about the privacy of their personal health information. Progress has been made by the federal government to develop national health information security and privacy protection standards, and Alaskans have participated in these efforts, but more work remains to be done.

Recommendations:

D2a: The Commission recommends that the Governor direct the Department of Health & Social Services to explore options for assisting providers (particularly smaller primary care practices and individual primary care providers) with adoption of electronic health record systems.

D2b: The Commission recommends that the Governor ensure Alaska's statewide health information exchange supports providers who have not yet adopted their own electronic health record system by facilitating identification and purchase of systems that are interoperable with the state exchange.

D2c: The Commission recommends that the Governor ensure that HIT is utilized to protect the public's health. Alaska's health information exchange should connect with electronic public health reporting systems to enable real-time disease reporting and rapid identification of public health threats.

D2d: The Commission recommends that the Governor ensure that data available through the statewide health information exchange is utilized to identify opportunities for administrative efficiencies, coordination and optimization of care, and health care quality and safety improvement.

D2e: The Commission recommends that the 2010 Alaska Health Care Commission track the development of the Alaska Statewide Health Information Exchange, Alaska's new Medicaid Management Information System (MMIS), and the use of ARRA funds for electronic health record deployment; and the Commission should continue to identify current issues, policy choices and recommendations based on these developments.

3. Telehealth/Telemedicine

Findings:

D3a: Alaskans have been particularly innovative in the use of telecommunications technologies as one way to bridge our vast geography and address health care access challenges.

D3b: Barriers to adoption and use of telemedicine include:[18]

- Insufficient telecommunications connectivity in some rural Alaskan communities;
- Inadequate access to training for providers and their staff;
- Medical licensure restrictions across state borders;
- Misalignment of payment systems between costs and benefits.

Recommendations:

D3a: The Commission recommends that the Governor and Alaska legislature work with federal and local partners to ensure all Alaskan communities have access to broadband telecommunications infrastructure that provides the connectivity and bandwidth necessary to optimize use of health information technologies.

[18] The order of the bullets in this finding is not meant to imply priority order of significance.

D3b: The Commission recommends that the Governor direct the Alaska Department of Health & Social Services to investigate innovative reimbursement mechanisms for telemedicine-delivered services; test new payment methodologies through Medicaid, and work with other payers to encourage adoption of successful methodologies.

E. Access to Primary Care for Medicare Patients

Findings:

E(a): Alaska's Medicare-eligible population is growing.

E(b): Medicare patients in some areas of Alaska experience trouble accessing primary care. The communities experiencing the most trouble with access are those with larger populations, notably Anchorage.

E(c): One contributor to the Medicare access problem is an insufficient supply of primary care physicians willing to accept and retain Medicare patients in larger urban centers.

E(d): Health care providers report Medicare's burdensome administrative requirements, onerous audits, and what they find to be insufficient reimbursement rates as the primary reasons for limiting or denying provision of Medicare services.

E(e): Care for Medicare patients is often more complex and time-intensive than for the general patient population.

E(f): Mid-level practitioners are increasingly being used to solve the Medicare access problem.

E(g): Health care providers report Medicare's physician and mid-level practitioner reimbursement schemes are not rational and not reliable.

E(h): Health care providers commonly report that Medicare's audit process designed to weed out fraud and abuse in the system focuses more on identification of billing errors than intentional fraud, incentivizes audit contractors to pursue and penalize providers for unintentional billing errors, and unnecessarily places an onerous administrative and legal burden on providers. The audit process, which appears to physicians to be based on an assumption of guilt, serves as a disincentive for Alaska providers to provide care for Medicare patients.

Recommendations:

E(a): The Commission recommends that the Governor and Alaska Legislature improve the supply of primary care providers in order to enable increased access to care for Medicare patients by:

- Supporting a student loan repayment and financial incentive program for primary care providers practicing in Alaska and serving Medicare patients (and including other service requirements deemed necessary to meet the needs of the underserved);
- Supporting development of a primary care internal medicine residency program;
- Supporting WWAMI program expansion as resources allow; and,
- Supporting mid-level practitioner development.

E(b): The Commission recommends that the Governor and Alaska Legislature explore strategies for removing barriers to the development of designated Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), facilitating development through state application for federal shortage designations for Medicare populations and supporting planning for new and expanded FQHCs/RHCs.

E(c): The Commission recommends that the Governor and Alaska Legislature work with Alaska's Congressional delegation to improve Medicare's reimbursement scheme to ensure the sustainability of care to Medicare patients.

E(d): The Commission recommends that the Governor and Alaska Legislature ask Alaska's congressional delegation to pursue federal policies to redesign the Medicare audit process so that it focuses more on identification and prosecution of fraudulent practices than on billing errors. Reported financial incentives for audit contractors should be eliminated and replaced with performance measures. Concern over billing errors should be addressed through provider training and performance reports, not through audit processes designed to weed out fraud and abuse.

E(e): The Commission recommends that the Governor and Alaska Legislature commission an analysis comparing Medicare to Medicaid and private insurance administrative requirements, including recommendations for streamlining public insurance administrative procedures to make them more user-friendly.

E(f): The Commission recommends that the Governor facilitate development of PACE programs in Alaska by directing the Department of Health & Social Services to submit a State Plan Amendment to the U.S. Centers for Medicare and Medicaid Services (CMS) to add PACE as a Medicaid service, and to identify and remove barriers to development of PACE programs.